

REFERRING CSO	DATE
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ADATSA/ADULT ASSESSMENT REFERRAL

SECTION A. IDENTIFYING INFORMATION

1. CLIENT LAST NAME		FIRST NAME	MIDDLE NAME
2. DATE OF BIRTH	3. ACES CLIENT NUMBER	4. GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	5. SOCIAL SECURITY NUMBER
6. CLIENT TELEPHONE OR MESSAGE NUMBER		7. LIMITED ENGLISH PROFICIENCY? PRIMARY LANGUAGE: <input type="checkbox"/> No <input type="checkbox"/> Yes	
8. ADDRESS: STREET		CITY	STATE ZIP CODE

SECTION B. ASSESSMENT APPOINTMENT INFORMATION

1. 평가센터 이름	2. 전화번호
3. 주소	
4. 약속날짜	5. 약속시간

주요: 귀하의 약속에 출석하실 때는 이 서류(및 첨부물)를 지참하고 가십시오. 상기한 약속을 지키지 않으시면 귀하의 혜택이 거부되거나, 지연되거나, 중단되는 결과를 초래하게 됩니다. 평가센터가 지정한 치료 프로그램을 받아들이지 않으시면 귀하가 치료를 거절하신다는 뜻으로 해석되어 거부되고, 중단되고, 벌금이 부과될 수 있습니다. 치료받아야 하는 필수사항에 대한 질문이 있으시면, 귀하의 지역사무소(CSO) 직원에게 문의하시기 바랍니다.

SECTION C. TO ASSESSMENT CENTER

1. DATE OF APPLICATION	2. NAME OF REFERRING AGENCY, OTHER THAN CSO(I.E., HOSPITAL, JAIL, DETOX, ETC., IF APPLICABLE)	3. AGENCY TELEPHONE NUMBER
4. CLIENT TYPE (CHECK ALL THAT APPLY) <input type="checkbox"/> TANF <input type="checkbox"/> PPW <input type="checkbox"/> ADATSA <input type="checkbox"/> SSI/GAX <input type="checkbox"/> Other: _____		
5. PRIORITY GROUP: <input type="checkbox"/> Pregnant <input type="checkbox"/> CPS Referral <input type="checkbox"/> I. V. Drug <input type="checkbox"/> HH/Children <input type="checkbox"/> Regular ADATSA (No Priority)		
6. The above named client is (Check appropriate box): <input type="checkbox"/> Applicant <input type="checkbox"/> Current Recipient <input type="checkbox"/> Transfer from another program <input type="checkbox"/> A. 고객은 타이를 XIX CNP 수혜자격이 있음. PIC 번호 _____ <input type="checkbox"/> 타에어엔에프(TANF) <input type="checkbox"/> 에스에스아이(SSI) <input type="checkbox"/> 기타: _____ 또는 <input type="checkbox"/> 의료신분증의 사본을 첨부하십시오. <input type="checkbox"/> B. 아닷사(ADATSA) 서비스를 신청함. <input type="checkbox"/> C. <input type="checkbox"/> 아닷사(ADATSA) 또는 지에이유(GAU)(두 사람 <input type="checkbox"/> 지에이유(GAU) 수혜자격 성립 <input type="checkbox"/> 지에이유(GAU) 수혜자격 미결 모두 신청함) <input type="checkbox"/> D. 이 고객을 의뢰한 그외 사유? _____		
7. <input type="checkbox"/> Other incapacity/health problems: _____ <input type="checkbox"/> A. Other evaluations pending (indicate type and date scheduled): _____ <input type="checkbox"/> B. Medical/psychological information attached. <input type="checkbox"/> Screening information attached. <input type="checkbox"/> C. Special needs for this client. Describe: _____		
8. Comments/Other: _____		
9. FINANCIAL WORKER/CASE MANAGER	TELEPHONE NUMBER	10. SOCIAL WORKER TELEPHONE NUMBER

The initiating worker:

1. Enters the referring community Services Office (CSO) name and current date.
2. Completes Section A, including the client's full name. The full middle name (not just initial) is requested.
3. Completes Section B when the assessment appointment is established.
4. Completes Section C:
 - A. Item 1 designates date the application was initiated.
 - B. Completes Items 2 and 3 by entering the name and telephone number of the agency or other entity that prompted the individual to seek chemical dependency services.
 - C. Item 4 designates client's program type(s).
 - D. Completes Item 5 designating the client's priority category by:
 - 1) Checking "Pregnant" for anyone currently pregnant or up to two months postpartum;
 - 2) Checking "CPS Referral" for anyone that is a direct referral for chemical dependency services from Children Protective Services;
 - 3) Checking "I.V. Drug" for anyone that is an intravenous drug user;
 - 4) Checking "HH/Children" for individuals with children in the home;
 - 5) Checking "No Priority" for everyone not included in the first four priorities.

NOTE: If the client is pregnant, contact the local assessment center immediately for an assessment, as these individuals are fast tracked through the assessment process.

E. Completes either A, B, or C in Item 6, as appropriate. If Item A is checked, indicate Title XIX the PIC code for medical coverage.

5. Completes Items 7 and 8 as needed. Checks Item 7C if the client has a special need.

6. Completes Items 9 and/or 10 with the names and telephone numbers of the referring financial and social workers.